

# Provider Insider

Alabama Medicaid Bulletin

January 2006

The checkwrite schedule is as follows:

01/06/06 01/20/06 02/03/06 02/17/06 03/03/06

As always, the release of direct deposits and checks depends on the availability of funds.

## HIPAA Mandates a Unique Health Identifier for Providers

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated that the Secretary of Health and Human Services (HHS) adopt a standard unique health identifier for health care providers.

On January 23, 2004, HHS published the Final Rule that adopts the National Provider Identifier (NPI) as the standard unique health identifier for health care providers. On May 23, 2005 Healthcare providers could begin applying for NPIs.

The compliance date for all covered entities is May 23, 2007, except that small health plans do not need to comply until May 23, 2008. When the NPI is implemented, covered entities will use only the NPI to identify health care providers in all standard transactions. Legacy identification numbers (e.g., UPIN, Blue Cross and Blue Shield Numbers, CHAMPUS Number, Medicaid Number, etc.) will not be permitted. Health care providers will no longer have to keep track of multiple numbers to identify themselves in standard transactions with one or more health plans. However, the Taxpayer Identifying Number may need to be reported for tax purposes as required by the implementation specifications.

The NPI is a numeric 10-digit identifier, consisting of 9 numbers plus a check-digit in the 10th position. It is accommodated in all standard transactions, and contains no embedded information about the health care provider that it identifies. The assigned NPI does not expire; and at the current rate of health care provider growth, can continue to be assigned for 200 years. All health care providers, as defined in 45 CFR 160.103, are eligible for NPIs. Health care providers who transmit any health information in electronic form in HIPAA mandated transaction are required to obtain and use NPIs. Health care providers who are not considered covered entities may also apply and be assigned an NPI. However, entities that do not provide health care (e.g., transportation services) are not eligible to be assigned NPIs because they do not meet the definition of "health care provider" and are not subject to HIPAA regulations.

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## Pass It On!

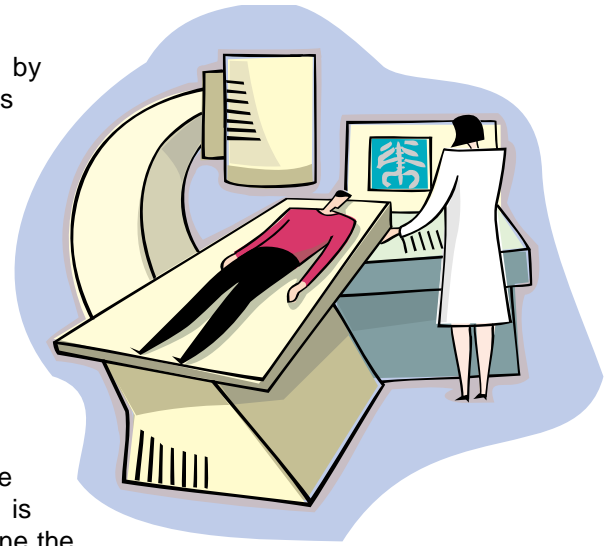
Everyone needs to know  
the latest about Medicaid.

Be sure to route this to:

- ☐ Office Manager
- ☐ Billing Dept.
- ☐ Medical/Clinical Professionals
- ☐ Other \_\_\_\_\_

## Examples for When to Use Modifier 59

Modifier '59' (distinct procedural service) may now be utilized by radiology providers to identify a distinct service. When radiology services are performed, modifier '59' should be used to report procedures that are distinct or independent. Modifier '59' should not be used when a more descriptive modifier is available. The following are three different examples of appropriate billing of radiology codes with modifier '59':



### Example 1

Diagnostic angiography (arteriogram/venogram) performed on the same date of service by the same provider as a percutaneous intravascular interventional procedure should be reported with modifier – 59. If a diagnostic angiogram (fluoroscopic or computed tomographic) was performed prior to the date of the percutaneous intravascular interventional procedure, a second diagnostic angiogram cannot be reported on the date of the percutaneous intravascular interventional procedure unless it is medically reasonable and necessary to repeat the study to further define the anatomy and pathology. Report the repeat angiogram with modifier – 59.

### Example 2

CPT codes 76375 (76376, 76377 in 2006) (3-D rendering) are not separately reportable for nuclear medicine procedures (CPT codes 78000-78999). However, CPT code 76375 (76376, 76377 in 2006) may be separately reported with modifier – 59 on the same date of service as a nuclear medicine procedure if the 3D rendering procedure is performed in association with a third procedure (other than nuclear medicine) for which 3D rendering is appropriately reported.

### Example 3

Radiation planning procedures may occasionally be repeated during a course of radiation treatment. Modifier – 59 may be utilized to CPT code 77336 when the radiation planning procedure and continuing medical physics consultation occur on the same date of service.

**Note:** Modifier 59 may also be utilized for surgical and/or procedure codes. This modifier should only be used to show a distinct procedural service when a comprehensive / component pair is billed and to communicate the appropriate unbundling of the code pair. For more detailed explanation of Modifier 59 use, please refer to the March 2005 Insider and the Alabama Medicaid Provider Manual, Chapter 28 Physician Chapter.

## Modifier 59 (Distinct Procedural Service) Claim Submission

Claims with Modifier 59 for multiple surgeries and/or procedures are individually reviewed to determine if comprehensive/component code pairs or services should be unbundled. In most instances, the most comprehensive code only should be billed and the component should be denied as rebundled or mutually exclusive.

In order to communicate the special circumstances of the comprehensive/component code pair unbundling, diagnoses codes and anatomical modifiers must be utilized as appropriate on the claim form. Claims are manually and individually reviewed to determine the special circumstances of unbundling code pairs.

In some cases, it may be necessary to submit a paper claim with an operative report attached to further explain the reason for the unbundling of code pairs. Please be sure to indicate "see attachment" in Block 19 on the paper claim form. The paper claim and attachment should be submitted to EDS for processing.

Your EDS Provider Representative may assist you with the filing and billing of Medicaid claims. You may call the Provider Assistance Center at 1-800-688-7979 for assistance and/or to speak with your Provider Representative for your area. For more information on Modifiers, please refer to your Alabama Medicaid Provider Manual, Chapter 28, Physician, Section 28.5.3.

## Provider Transplant Guidelines

**W**ith the exception of cornea transplants, all Medicaid-covered transplants must be prior authorized and are limited to in-state providers unless there are no in-state providers to perform the procedure.

All prior authorized transplants must be coordinated through the University of Alabama Birmingham's transplant staff prior to referring the recipient to an OUT OF STATE PROVIDER OR FACILITY. THERE ARE NO EXCEPTIONS. Additional information may be obtained by calling Alabama Medicaid's Transplant Program at 334-242-5455.

## **Important Information for Pharmacy Providers Regarding Claim Recoupments**

**B**eginning January 1, 2006, Medicaid will deny all prescription drug claims (other than Part D excludable drugs) for Medicaid recipients who have Part A and/or B Medicare coverage at the time a prescription is dispensed. This denial will be based upon Medicare entitlement dates. Because there is sometimes a delay in Medicaid receiving Medicare entitlement dates, Medicaid may pay for some prescription drug claims that should have been covered by Medicare Part D. To correct any erroneous payments, Medicaid will implement a monthly process in January 2006 to recoup all drug claims (other than Part D excludable drugs) that were paid by Medicaid for recipients who were enrolled in a Medicare Part D plan at the time claims were dispensed.

Providers dispensing Part D covered drugs will have a process to verify Medicare Part D enrollment of their customers. To reduce the potential for recoupment of drug claims by Medicaid, providers are strongly advised to verify Part D enrollment at the time prescriptions are filled. If you have any questions regarding this recoupment process, you may contact Kay Keeshan at 334-242-5248 or Keith Thompson at 334-242-5281.

### **Attention Providers Submitting Prior Authorization Requests**

**P**lease note that the PA Types have been changed to HIPAA compliant Service Types. The revised PA Form 342 is available on the web. If you are a Dental Provider, please continue to use Form 343 for your paper PA requests. If you submit electronically please use the most current version of the Provider Electronic Solutions software, currently version 2.05. If you are submitting through a vendor then they should be using the HIPAA compliant service types indicated in the box below.

If you have submitted PA requests electronically using the incorrect HIPAA Service Types, please resubmit with the correct Service Type indicating the PA number originally submitted. In PES, (56) Ground Ambulance is Medically Related Transportation and (AE) Physical Therapy is Physical Medicine.

#### **HIPAA Compliant Service Types**

(01) Medical Care	(69) Maternity
(02) Surgical	(72) Inhalation Therapy
(12) DME-Purchase	(74) Private Duty Nursing
(18) DME-Rental	(75) Prosthetic Device
(35) Dental Care	(A7) Psychiatric-Inpatient
(42) Home Health Care	(AC) Targeted Case Mgmt
(44) Home Health Visits	(AD) Occupational Therapy
(48) Hospital Inpatient Stay	(AE) Physical Therapy
(54) LTC Waiver	(AF) Speech Therapy
(56) Ground Transportation	(AL) Vision-Optometry
(57) Air Transportation	

## **Attention Ambulance Providers**

**E**ffective for dates of service beginning with October 11, 2005 guidelines for **PA requests for non-emergency transportation** have been revised. The request must still have a valid diagnosis code; however it is not restricted to the list of diagnosis codes in Medicaid's Provider Manual Chapter 8, (Ambulance).

All transportation must be medically necessary and reasonable and documentation must state one of the condition(s) listed below that necessitate ambulance service and indicate why the recipient cannot be transported by another mode of transportation:

<b>Code</b>	<b>Description</b>
02	Bed confined before the ambulance service
04	Moved by stretcher
05	Unconscious or in shock
07	Physically restrained
08	Visible hemorrhaging

Please note that condition codes 06 (Transported in an emergency situation) and 09 (Medically necessary) are no longer condition codes that are recognized by Alabama Medicaid for non-emergency ground ambulance transport.

When submitting paper PA requests via Form 342, please place the appropriate condition code in the "Patient Condition" field and also in the "Clinical Statement" section. The patient's condition should also be further described and included in the documentation justifying why the patient required/requires transport by ambulance.

If you submit PA requests electronically, (278 transaction via PES), the "Patient Condition Category" under Service Tab 1 should indicate 07 for Ambulance Certification and the "Patient Condition" should be indicated by one of the condition codes above and **service type should always be 56**. In addition, in Header 3, "Clinical Statement", should include the medical justification of why the patient required/requires transport by ambulance as you would in this same section via Form 342.

Specific instructions can be found in Alabama Medicaid's Provider Manual, Chapter 4 (Prior Authorization). If you have any questions please call Janice Barnes at 334-353-4771 or Carol Akin at 334-242-5580.

### **Patient 1<sup>st</sup> Information Can Be Downloaded Electronically**

**P**atient 1<sup>st</sup> Providers now have the capability to download files electronically. If you are interested in receiving electronic files, please contact the EMS Helpdesk at 1-800-456-1242 for instructions on usage and how to create a password. The files currently available for download are the Patient 1<sup>st</sup> Roster (PT1) and the Patient 1<sup>st</sup> Assignment List (PT5).

**[www.medicaid.state.al.us](http://www.medicaid.state.al.us)**

## ***HIPAA Mandates a Unique Health Identifier for Providers*** (Continued From Page 1)

In certain situations, it is possible for “subparts” of organization health care providers (such as hospitals) to be assigned NPIs. These subparts may need to be assigned NPIs in order to conduct standard transactions on their own behalf or to meet Federal regulatory requirements related to their participation in health plans such as Medicare. The Final Rule requires covered health care providers to determine if they have subparts that may need NPIs and, if so, to obtain NPIs for the subparts or require the subparts to obtain their own NPIs. The subpart concept does not pertain to health care providers who are individuals. We are advising providers request an NPI number for each Medicaid number they currently use in filing claims, if allowed by NPI. This will streamline the process of submitting your claims to EDS for processing.

Health care providers will be assigned NPIs upon successful completion of an application. To apply online for an NPI, visit: <https://nppes.cms.hhs.gov> or call toll free (800) 465-3203 to request a paper application.

## ***Medicaid Identifies Problem in Benefit Limit for Recipients***

Medicaid identified a system problem where a recipient’s services may have been denied in error for the benefit limitation being exceeded. These claims would appear on your October and November EOPs with a rejection code of 119 (benefit maximum for this time period has been reached). This error would only occur if the recipient had both an outpatient claim and any other claim type in the system at the same time.

The system has been fixed. If you received an exceeded benefit rejection and feel this rejection is in error, please resubmit your claim to EDS for processing.

## ***Medicaid Maternity District Office Six and Twelve Contact Information Has Changed***

Two of the Medicaid District Offices have changes with their contact information. For District Office Six, Martha Jinright is the new name for their contact person. For District Office Twelve, a new provider phone number, (877) 465-1378, has been added and (251) 575-4213 is their new FAX number.



**Alabama  
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